CAP-MR/DD SERVICES CHECKLIST

Please return this Checklist with your application packet to the DMH/DD/SAS, Audit Branch, 3012 Mail Service Center, Raleigh, NC 27699-3012.

Please answer Yes or No to the following services, if applicable:

Day Habilitation

Are you intending to provide this service in a licensed facility?
Yes _____ No _____

Developmental Day Services

Are you intending to provide this service in a licensed facility?
Yes _____ No _____

In-Home Aide Level I

Are you intending to provide this service in a licensed facility?
Yes _____ No _____

Personal Care

Are you intending to provide this service in a licensed facility?
Yes _____ No _____

Respite Care—Non-Institutional Nursing Based

Are you intending to provide this service in a licensed facility?
Yes _____ No _____

Supported Employment

Are you intending to provide this service in a licensed facility?
Yes _____ No _____

Supported Living

Are you intending to provide this service in a licensed facility?
Yes _____ No _____

Therapeutic Case Consultation

Are you intending to provide this service in a licensed facility?
Yes _____ No _____

If Yes to any of the above, please include a copy of the facility's license in your application packet to expedite your enrollment.